Testimony
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Availability and Effectiveness of Programs to Treat Methamphetamine Abuse

Statement of

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Mr. Chairman and Members of the Subcommittee, I am Charles G. Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). I am pleased to present SAMHSA's substance abuse prevention and treatment response to the threat of methamphetamine. It is abundantly clear that many of our most pressing public health, public safety, and human services needs have a direct link to substance use disorders. This obvious link is why the Administration places such a great importance on increasing the Nation's public health approach to prevention and to increasing the Nation's substance abuse treatment capacity.

SAMHSA is working to do just that. Our everyday work at SAMHSA is structured around our vision of "a life in the community for everyone" and our mission "to build resilience and facilitate recovery." Our collaborative efforts with our Federal partners, States and local communities, and faith-based organizations, consumers, families, and providers are central to achieving both our vision and mission. Together, we are working to ensure that the 19.1 million current illicit drug users in America have the opportunity to live, work, learn, and enjoy healthy lifestyles in communities across the country.

Equipping communities with substance abuse treatment capacity is a clear priority for the President, HHS Secretary Leavitt, and Office of National Drug Control Policy (ONDCP) Director Walters. The Administration has embarked on a strategy that has two basic elements: demand reduction; and disrupting the market for illegal drugs.

This drug control strategy is backed by $12.5 billion in the Fiscal Year (FY) 2006 Budget. SAMHSA has a lead role to play in the demand reduction side of the equation. SAMHSA helps stop drug use before it starts through education and community action, and we heal America's drug users by supporting treatment resources where they are needed.

I am pleased to report that our strategy is working. By focusing our attention, energy, and resources, we as a nation have made real progress. The most recent data from the 2005 Monitoring the Future Survey, funded by the National Institute on Drug Abuse (NIDA), confirms that we are steadily accomplishing the President's goal to reduce teen drug use by 25 percent in five years. The President set this goal with a two-year benchmark reduction of 10 percent. Last year, we met and exceeded that goal. Now at the four-year mark, we have seen a 19 percent reduction, and there are now 700,000 fewer teens using drugs than there were in 2001.

Additionally, the most recent findings from SAMHSA's 2004 National Survey on Drug Use and Health clearly confirm that more American youth are getting the message that drugs are illegal, dangerous, and wrong. For example, 35 percent of youth in 2004 perceived that smoking marijuana once a month was a great risk, as opposed to 32.4 percent of youth in 2002. This is an indication that our partnerships and the work of prevention professionals, schools, parents, teachers, law enforcement, religious leaders, and local community anti-drug coalitions are paying off.

We know that when we push against the drug problem, it recedes, and fortunately, today we

know more about what works in prevention, education, and treatment than ever before. We also know our work is far from over. In particular, we continue to be very concerned about abuse of prescription drugs and methamphetamine. The use of methamphetamine continues its assault as an extremely serious problem, the intensity of which is overcoming the ability of many communities to cope. Local and county resources for law enforcement, investigations, incarcerations, emergency medical care, prevention and treatment for those addicted and the many services needed by the children of the adults who manufacturer and or use the drug are challenging many communities. And then there is the human lose of friends, neighbors, and relatives.

THE GROWTH OF METHAMPHETAMINE USE

In the early to mid 1990s, SAMHSA's Drug Abuse Warning Network (DAWN) data served as an early warning about the rise of methamphetamine use. DAWN is a public health surveillance system that monitors drug-related visits to hospital emergency departments and drug-related deaths that are investigated and reported by medical examiners and coroners across the country.

Almost immediately, this early alert from DAWN was confirmed through another SAMHSA data reporting and analysis system, the Treatment Episode Data Set (TEDS). TEDS provides information on the demographic and substance abuse characteristics of the 1.9 million annual admissions to facilities that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services. As early as 1992, TEDS data had indicated that methamphetamine treatment admissions were accounting for about 1 percent of all admissions. Our most current 2004 TEDS data indicates the proportion of admissions for abuse of methamphetamine has grown from 1 percent in 1992 to 7 percent in 2004. In 2004 there were 129,079 treatment admissions for primary methamphetamine abuse, an increase of 286% since 1994.

Of those admitted in 2004 for the treatment of methamphetamine use, three-quarters (73 percent) were white and half (55 percent) of the admissions were male, with an average age at admission of 31 years. The percentage of Hispanics has increased significantly, from 9 percent in 1993 to 16 percent in 2004. For Blacks, the percentage was 3 percent in 1993 and 2.5 percent in 2004. For American Indian/Alaskan Natives, it remained at 2 percent. For Asians and Pacific Islanders, the percentage has increased from 2 percent in 1993 to 3 percent in 2004. The NSDUH reports that young adults aged 18-25 had the highest rate of methamphetamine use among the 12 million Americans over the age of 12 who have used this illicit drug. Fortunately, the rates of past-year methamphetamine use among youths age 12-17 declined from 2002 to 2004, from 0.9 percent to 0.6 percent.

DAWN and TEDS data documented consequences and a geographic pattern of methamphetamine use among the U.S. population. Initially a problem in a few urban areas in the Southwest, methamphetamine use spread to several major Western cities and then east from the Pacific States into the Midwest, and now through the South and Southeast. This destructive path from West to East has also created a major drug problem in rural America.

The alarming data about methamphetamine use and, in part, its popularity can be explained by the drug's wide availability, ease of production, low cost, and its highly addictive nature. It is often produced in small, makeshift "laboratories," using equipment and ingredients that are – for the most part – readily available at local drug, hardware, and farm supply stores. The instructions for making methamphetamine are easily found on the Internet, and the equipment needed is as simple as coffee filters, mason jars, and plastic soda or water bottles. In addition, the easy availability and low cost of the essential ingredient, ephedrine or psuedoephedrine, makes methamphetamine inexpensive. As you know, these substances are commonly found in certain prescription and non-prescription allergy and cold medications. Producing an entire batch of methamphetamine can take less than four hours from start to finish, making it more readily available than other illicit drugs.

Complicating the efforts to stop methamphetamine's growth is its highly addictive nature. Immediately, methamphetamine use produces a brief but intense "rush," followed by a long-lasting sense of euphoria that is caused by the release of high levels of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure. Eventually, methamphetamine leads to addiction by altering the brain and causing the user to seek out and use more methamphetamine in a compulsive manner. Chronic use leads to increased tolerance of the drug and damages the ability of the brain to produce and release dopamine. As a result, the user must take higher or more frequent doses in order to experience the pleasurable effects or even just to maintain feelings of normalcy.

Methamphetamine users and their families, in addition to drug treatment programs, often rely on emergency rooms, the primary health care system, the mental health care system, child and family services, and the criminal justice system. As a result, addressing methamphetamine use often requires collaboration among law enforcement officers, prosecutors, judges, probation officers, treatment providers, prevention specialists, child welfare workers, legislators, business people, educators, retailers, and a number of other individuals, agencies, and organizations, who all have critical roles in the prevention and treatment process.

SAMHSA'S ROLE IN PREVENTION

SAMHSA's earlier efforts in preventing methamphetamine abuse were channeled through its Center for Substance Abuse Prevention's (CSAP) Methamphetamine and Inhalant Prevention Initiative. This initiative funded grantees that were battling methamphetamine's growth in communities across the country. For example, in Oregon, health officials were reporting an increase in the number of youth who were seeking treatment for addiction to methamphetamine. In 2002, the "Oregon Partnership Methamphetamine Awareness Project" was awarded a SAMHSA grant that targeted 9th and 10th grade students over a three-year period to prevent substance abuse among young people in school and community settings in rural Oregon. CSAP's Methamphetamine and Inhalant Prevention Initiative was designed to conduct targeted capacity expansion of methamphetamine and inhalant prevention programs and/or infrastructure development at both State and community levels.

SAMHSA recently closed a request for applications announcing that $3.3 million in funds was

available for 10 to 12 grants focusing on methamphetamine prevention. These grants likely will be announced in August.

To more effectively and efficiently align and focus our prevention resources, SAMHSA launched the Strategic Prevention Framework in 2004. SAMHSA awarded Strategic Prevention Framework grants to 25 States and 2 territories to advance community-based programs for substance abuse prevention, mental health promotion, and mental illness prevention. By the end of FY 2006, nearly 40 States will have received a grant under this program. These grantees are working with our Centers for the Application of Prevention Technology to systematically implement a risk and protective factor approach to prevention across the Nation. Whether we speak about abstinence or rejecting drugs, tobacco, and alcohol; or whether we are promoting exercise and a healthy diet, preventing violence, or promoting mental health, we really are all working towards the same objective – reducing risk factors and promoting protective factors.

The success of the framework rests in large part on the tremendous work that comes from grass-roots community anti-drug coalitions. That is why we are so pleased to be working with the ONDCP to administer the Drug-Free Communities Program. This program supports approximately 759 community coalitions across the country. Consistent with the Strategic Prevention Framework and the Drug Free Communities grant programs, we are transitioning our drug-specific programs to a risk and protective factor approach to prevention. This approach also provides States and communities with the flexibility to target their dollars in the areas of greatest need.

SAMHSA'S ROLE IN TREATMENT

While the number of individuals who have used methamphetamine in their lifetimes, in the past year, or in the past month has not grown in the past few years, the level of dependence on the drug has. In 2002, 27.5% of those who said they used methamphetamine in the past month met the definition of being dependent. In 2004 the percentage was 59.3%. You should also know that the average person presenting themselves for treatment today for methamphetamine addiction has been using methamphetamine for over 7 years. The level of dependence and the length of use present challenges to treatment providers.

SAMHSA supports treatment through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Substance Abuse Prevention and Treatment Programs of Regional and National Significance (PRNS). SAPT Block Grant funds, appropriated at $1.6 billion, are distributed to States using a formula dictated in statute. States have considerable flexibility in their use of the funds. These funds, however, typically are used to maintain the current treatment system.

We also support treatment through competitive grants whereby public and non-profit private entities apply directly to SAMHSA for funds in areas chosen by the agency after consultation with stakeholders. Applications are reviewed and scored by experts from outside Federal government, and SAMHSA funds those with the best scores.

One such competitive program is our Targeted Capacity Expansion (TCE) program under which SAMHSA continues to help States identify and address new and emerging trends in substance abuse treatment needs. In FY 2004, SAMHSA awarded TCE funds to programs in California, Texas, Oregon, and Washington to provide treatment for persons addicted to methamphetamine, and three other grants focused on methamphetamine were awarded to Hawaii and Iowa for a total of $943,000. In FY 2005, SAMHSA awarded an additional 12 TCE grants in New Mexico, Georgia, Tennessee, Oregon, Texas, Montana, South Dakota, and California. This year we intend to go further down the list of approved TCE grants from last year to fund 7 more grants with $3.4 million.

In his 2003 State of the Union Address, President Bush resolved to help people with a drug problem who sought treatment but could not find it. He proposed Access to Recovery (ATR), a new consumer-driven approach for obtaining treatment and sustaining recovery through a State-run voucher program. State interest in ATR was overwhelming. In FY 2004, sixty-six States, territories, and Tribal organizations applied and competed for $99 million in funding, and in August 2004 we awarded grants to 14 States and one Tribal organization for those funds. Because the need for treatment is great - as methamphetamine abuse treatment episodes alone have demonstrated – the Administration has consistently – in FYs 2004, 2005 and 2006 – proposed more funding for treatment and recovery support services through ATR than Congress has appropriated.

Of the States that are now implementing ATR, Tennessee and Wyoming have invested $20.6 million on methamphetamine. The State of Tennessee is using ATR-funded vouchers to expand treatment services and recovery support services in the Appalachians and other rural areas of Tennessee for individuals who abuse or are addicted primarily to methamphetamine. The Wyoming ATR program is also addressing the methamphetamine problem, focusing its efforts on Natrona County. This county has the second-highest treatment need in the State and is considered to be at the center of the current methamphetamine epidemic in Wyoming.

Wyoming and Tennessee are just two examples of ATR's potential. ATR's use of vouchers, coupled with State flexibility, offer an unparalleled opportunity to create profound positive change in substance abuse treatment financing and service delivery across the Nation.

The Administration has requested nearly $100 million for FY 2007 for a new cohort of ATR grants, $25 million of which would be ATR grants specifically focused on methamphetamine. ATR is a valuable program that gives clients the opportunity to participate in deciding their path to recovery and it gives States an opportunity to choose to incorporate recovery support services into the current treatment system to improve outcomes.

SCIENCE TO SERVICE

To help better serve people with substance use disorders, a true partnership has emerged between SAMHSA and the National Institutes of Health (NIH). Our common goal is to more rapidly deliver research-based practices to the communities that provide services. SAMHSA is partnering with the pertinent NIH research Institutes – NIDA, the National Institute on Alcohol

Abuse and Alcoholism, and the National Institute of Mental Health – to advance a "Science to Service" cycle. Working both independently and collaboratively, we are committed to establishing pathways to rapidly move research findings into community-based practice and to reducing the gap between the initial development and widespread implementation of new and effective treatments and services.

As an example, SAMHSA began working on the problems resulting from methamphetamine in 1998 with a competitive grant program designed to expand on work done at NIDA on effective treatment for stimulants. The Methamphetamine Treatment Project (MTP) of SAMHSA's Center for Substance Abuse Treatment (CSAT) was the largest randomized clinical trial of treatments for methamphetamine dependence to date. Eight grants were funded in California, Hawaii, and Montana. This effort helped identify proven ways of treating those dependent on methamphetamine.

The clinical trials were used to evaluate and expand on the Matrix Model, developed in 1986 by the Matrix Institute with support from NIDA as an outpatient treatment model that was responsive to the needs of stimulant-abusing patients. CSAT compared the Matrix Model to other cognitive behavioral therapies. The result was the development and release of a scientific intensive outpatient curriculum for the treatment of methamphetamine addiction that maximizes recovery-based outcomes. Information on the Matrix Model and other cognitive behavioral approaches are available both in a set of two DVD's produced by our Pacific Southwest Addiction Technology Transfer Center (ATTC) and in our Treatment Improvement Protocol (TIP) #33 - Treatment for Stimulant Use Disorders. These are available through SAMHSA's National Clearinghouse for Alcohol and Drug Information (www.ncadi.samhsa.gov).

TIPs are best practice guidelines for the treatment of substance use disorders and are part of the SAMHSA's effort in conjunction with NIH to bring science to service. TIPs draw on the experience and knowledge of clinicians, researchers, and administrative experts. They are distributed to a growing number of facilities and individuals across the country. TIP #33 describes basic knowledge about the nature and treatment of stimulant use disorders. More specifically, it reviews what is currently known about treating the medical, psychiatric, and substance abuse/dependence problems associated with the use of two high-profile stimulants: cocaine and methamphetamine. SAMHSA has also published a Quick Guide for Clinicians as well as Knowledge Application Program (KAP) Keys that are also based on TIP #33

Education and dissemination of knowledge are key to combating methamphetamine use. Our ATTCs are providing training, workshops, and conferences to the field regarding methamphetamine. The Pacific Southwest ATTC has developed two digital Training Modules on Methamphetamine. Additionally, SAMHSA has collaborated with ONDCP, the National Guard Bureau's Counter Drug Office, NIDA, and the Community Anti-Drug Coalitions of America (CADCA) on a booklet, video tape, and PowerPoint presentation entitled, "Meth: What's Cooking in Your Neighborhood?" This package of products provides useful information on what methamphetamine is, what it does, why it seems appealing, and what the dangers of its use are.

Recently SAMHSA financed two conferences on methamphetamine for States, one for all the States west of the Mississippi and the other for the States east of the Mississippi. In each case, SAMHSA paid for States to bring 15 people each, including State and local officials and providers. SAMHSA brought in experts in the field of methamphetamine treatment and research in a well-received and much-needed opportunity to learn and share information about methamphetamine.

Within the past two weeks, we have provided each of the States and representatives of the Native American community with a compact disk of our compendium entitled, "Stimulant Use Treatment Manuals," produced by the Matrix Institute. These manuals are the result of the clinical trials run on cognitive behavioral therapies that were used in the CSAT Methamphetamine Treatment Project in 1999. They are a tutorial on how to implement cognitive behavior therapy and, in particular, the Matrix Model. Printed copies of the manual will be available shortly, and they will be distributed to States, local communities, and providers.

In conclusion, if we continue to foster these initiatives and further our goals of expanding substance abuse treatment capacity and recovery support services and of implementing the Strategic Prevention Framework, we will simultaneously better serve people in the criminal and juvenile justice systems, those with or at risk of HIV/AIDS and hepatitis, our homeless, our older adults, and our children and families. We are doing our part at SAMHSA. We have been building systemic change so that no matter what drug trend emerges in the future, States and communities will be equipped to address it immediately and effectively before it reaches a crisis level.

I appreciate this opportunity to provide this information to you, and I would be glad to answer any questions you may have.